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A District Branch of the
American Psychiatric Association

The Honorable Michael McRaith
State Director of Insurance
100 W. Randolph, Suite 9-385
Chicago, IL 60601

December 3, 2010

Dear Director McRaith:

I am writing on behalf of the Illinois Psychiatric Society (IPS), a state-wide organization of over 1100 psychiatrists. Below please find our comments with respect to the creation of a Health Benefit Exchange in Illinois:

I. Functions of a Health Benefit Exchange

Questions to Consider:

1. What advantages will Illinois see in operating its own exchange versus permitting the U.S. Department of Health and Human Services (HHS) to run an Exchange for the State?
2. What are the most desirable outcomes from an insurance market perspective? What features should the Exchange contain in order to reach those outcomes?
3. What, if any, Exchange functions beyond the minimum clearinghouse functions required in the ACA would benefit Illinois and why?
4. What advantages are presented to Illinois if the Exchange were to limit the number of plans offered; for example, plans could be required to compete on attributes such as price or quality rating? Is the Exchange a stronger marketplace if it permits "any willing provider" to sell coverage?

IPS Comment: Illinois could use its certification authority to require Exchange plans to submit bids to participate in the Exchange and limit participation to plans made most attractive bids in terms of price, value and other important variables. Massachusetts uses this practice.

II. Structure and Governance

Questions to Consider:

1. If the Illinois chooses to establish its own Exchange, which governance structure would best accomplish the goal of more affordable, accessible health insurance coverage? Why?

IPS Comment: The Exchange should be structured as a separate non-profit organization and should not be housed within the State Department of Insurance. This is because the

fundamental role of an Exchange is to market insurance products while the basic role of an insurance commissioner is to regulate insurance and protect consumers.

2. If the Exchange is run by an executive director and/or a governing board, what should be the expertise of those appointed? How long should the terms be? Are there existing models to which the State should look?

IPS Comment: The Board of the non-profit organization should include consumer advocates as well as representatives from the Illinois State Medical Society, the Illinois Hospital Association and other provider groups so that they can provide valuable input as to what should be included in policies. All healthcare insurers include physicians and other healthcare providers within their companies to help ensure proper care is included in policies. The Exchange should be no different.

III. The External Market and Addressing Adverse Selection

1. Should Illinois establish a dual market for health insurance coverage or should it eliminate the external individual market and require that all individual insurance be sold through the Exchange? What would be the effects of doing so?

IPS Comment: Having a single market would simplify consumer choices and make it easier for the Department of Insurance to monitor the insurers and their offerings. As long as individual or small group coverage is readily available outside the Exchange, the potential exists for healthy individuals and groups to purchase insurance disproportionately outside the exchange because they would prefer to pay less money to having more protection. If the Exchange becomes essentially a high-risk pool, the Exchange will become unattractive to insurers while coverage through the Exchange will become unaffordable to individuals and employers.

In addition, high-risk enrollees have traditionally tended to prefer PPOs with large networks as opposed to HMOs with tighter networks. Enrollees with chronic illnesses want access to a wide range of specialists and treatments. Higher risk enrollees also prefer plans with decreased cost sharing obligations and they are less likely to elect to leave more expensive plans for less expensive plans.

Keep the number of insurers to a manageable number as increasing the number of plan choices may encourage adverse selection. Older, less healthy enrollees are less likely to switch plans than younger healthier enrollees.

2. What other mechanisms to mitigate "adverse selection" (i.e. requiring the same rules for plans sold inside and outside of the Exchange) should the state consider implementing as part of an Exchange?

IPS Comment: In compliance with the Illinois parity law, all insurance for groups with 50 or more employees must include coverage for the mental illnesses included in the parity law. However, if all individual insurance is sold on the exchange but some policies include coverage for mental health, adverse selection will occur as some employers with 50 or more employees will be encouraged to just let their employees get coverage on the exchange so that the do not have to pay for coverage for mental health. In addition, if all policies on the exchange do not include coverage for mental health, this will cause people who need mental health coverage to have more limited options and would also cause people with mental illnesses to be in a specific risk pool and would not

distribute the risk throughout the risk pool.
Furthermore, substance abuse treatment should also be included in order to comply with federal law. Since Illinois parity law requires employers 50 or more employees to cover mental health care, and since the federal parity law requires companies to provide both mental health and substance use coverage when companies offer mental health coverage, Illinois should, at a minimum include substance abuse coverage for employers with 50 or more employees. Further, as discussed above, if all individual insurance is sold on the exchange but some policies include coverage for mental health, adverse selection will occur as some employers with 50 or more employees will be encouraged to just let their employees get coverage on the exchange so that they do not have to pay for coverage for mental health.

3. Are there hybrid models for the Exchange the State should consider? What characteristics do they offer that would benefit Illinoisans?

4. If the Exchange and the external market operate in parallel, what strategies and public policies should Illinois pursue to ensure the healthy operation of each? Should the same rules apply to plans sold inside and outside an Exchange? Should the same plans be sold inside and outside the Exchange without exception?

IPS Comment: Yes, the same plans should be sold inside and outside the Exchange to ensure an even distribution of the risk pool.

5. What rules (if any) should the State consider as part of establishing the open enrollment period?

6. The ACA requires states to adopt systems of risk adjustment and reinsurance for the first three years of Exchange operation. How should these tasks be approached in Illinois? What are issues the State should be aware of in establishing these mechanisms?

7. Given the new rules associated with the Exchange, and the options available for restructuring the current health insurance marketplace, what should the state consider as it relates to the role of agents and brokers?

Additional Comments:

1. **Transparency**: This is critical to the success of the Exchange.
    a. Group health plans and insurance issuers are required to report to HHS and to enrollees information describing their programs for improving health outcomes, decreasing hospital readmissions, implementing patient safety and error reduction programs on a website. The ACA also provides that the information should be made available through the Exchanges. IPS believes that providing the information on the Exchange's website is an essential component for transparency of the Exchange.
    b. The ACA still allows details not included in the Summary of the Plan. The Illinois Exchange should require the ACA required Summary of Coverage and Benefits must accurately describe the actual coverage of the plan and that if the terms disclosed in the ACA Summary contradict or are limited by the terms of the underlying policy or certificate of coverage to the detriment or potential detriment of the insured, the terms of the Summary prevail. Also, if a Summary does not address an issue under governing disclosure regulations, the insurer or group health plan may not enforce the limitation found in the contract that should have been disclosed.

c. So that the Department of Insurance can ensure that insurers comply with the ACA requirement that insurers spend at least 80% of their premium revenues (after various deductions) on costs of clinical care and quality improvement activities in the individual and small group market and 85% of the large group market. [Note: the phrase "quality improvement activities" should be defined so that it does not become a bucket for insurers to avoid the 80 or 85% requirement.]

2. **Enforcement**:
   a. Health plans should be contractually bound by the information they disclose on their websites.
   b. The Exchange must have the authority to review plans to:
      i. Ensure health plans meet certification requirements
      ii. Review, approve and/or deny premium rate increases.

Respectfully Submitted,

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Executive Director
Illinois Psychiatric Society